



Health Care at a Crossroads: Planning for the Future

Presented by:

*William E. (Bill) Hembree, Director
Health Research Institute
Concord, CA
(925) 676-2320, hembree_hri@att.biz*



Topics For Discussion

**Where is Health Care Headed?
Some Inconvenient Truths....
What Are The Challenges?
Barriers?
Solve the Challenges!
Critical Ingredients**



Where Is US Health Care Headed?

1. Status Quo, More of the Same
2. Employers- and/or Consumer-Driven Solutions
3. Health System Reform
 - More Tinkering?
 - Universal Coverage?
 - Single-Payer?
 - Mandates?



Some Inconvenient Truths....

- "More of the Same" is a Non-Solution
- Avoid Preconceptions
- No Simple, Easy Solution
- "Future Ain't What it Used to Be" *Yogi Berra*
- Planning & Stakeholders Are Critical
- When Perception and Reality Are Different.....Perception Counts



What Are the Challenges?

- Status Quo, More of the Same
Access Challenges
Health Care Anti-Economics
Unsustainable Costs
Quality of Care
Population Health

"The definition of insanity is doing the same thing over and over and expecting a different result" Albert Einstein



Fundamental Barriers to Health System Reform (Pick Two)

- Access
- Current and Future Costs
- Profound Resistance to Change



Access Challenges

- 44.8-89.6 Million Uninsured
- Added US Cost to Provide 100% Access? % Added to US' Cost

< \$50 Billion?	2.5%
\$51-250 Billion?	7.5%
> \$250 Billion?	12.5%



Access Cost/Benefit Tradeoff

- 100% Access = \$48 Billion (2004 Dollars)
- Benefits of Universal Coverage:
 - 5-15% Reduction in Mortality
 - 18,000 Fewer Deaths/Year
 - \$103 Billion in Economic Value

References: www.kff.org "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" and www.LOHL.edu "Care Without Coverage: Too Little, Too Late" and www.commonwealthfund.org "Bending the Curve" and "A High Performance Health System...An Ambitious Agenda for the Next President"



Health Care Anti-Economics

- Poor Care is Rewarded, Good Care Isn't
- Illness is Paid For, Not Health
- Primary/Specialty Ratio is Inefficient
- Non-Clinical Technology is Lagging
- Extremely Poor Data
- Ineffectiveness, Inefficiency Rewarded
- Declining Medical Market Competition
- Insulated Consumers, Uninspired Payers



Health Care Anti-Economics, continued

■ Results:

Most Expensive (Non-) System
in the World

	<u>Per-Capita</u>	<u>% GDP</u>
United States	\$6,711	16.0%
Canada	\$2,998	9.9%
Germany	\$2,983	10.6%
United Kingdom	\$2,517	7.8%



Health Care Anti-Economics, Continued

■ Near Third-World Population Health Statistics

<u>Measures</u>	<u>Ranking</u>
Adequacy of Nation's Health System	37 th (WHO)
Life Expectancy (@ 77.9 Years)	42 nd (NCHS)
Infant Mortality (@ 6.9/1000)	41 st (NCHS)



Past, Present and (Unsustainable) Future Costs

■ Past and Current Costs

	<u>1965</u>	<u>2007</u>
US Health Care Costs	\$41.6 Billion	\$2.1 Trillion
Per-Capita	\$204	\$7,551
% GDP	5.9%	16.0%
Cost/Employee	\$141	\$8,084

Past, Present and (Unsustainable) Future Costs

■ Tomorrow's (Unsustainable) Costs

	2017	2027
US Health Care Costs	\$4.5 Trillion	\$9.0 Trillion
% GDP	20.0%	24.8%
Cost/Employee (@ 8.9%)	\$20,704	\$48,567

Factors Influencing Future Health Care Costs

- Aging of US Population
- Insatiable Appetite for Care
- Illegal Immigration
- Epidemic of Health-Harming Lifestyles
- Alzheimer's Disease
- Genomics/Biotech/Technology
- Ethical Dilemmas, Rationing

Quality of Care Needs (Considerable) Improvement

Less-Than-Adequate Quality of Care

- Up to 98,000 Deaths (Medical Mistakes)
- 54.9% of Recommended Care
- Wide Variations, Optimal vs. Excessive
- 65 Million Avoidable Sick Days/Year
- \$10.6 Billion on-job Productivity Losses

References: HRI's White Paper, "Improving Health Care Quality: Can We? Should We? How?" and www.hospitalcompare.hhs.gov, WebMD, Healthgrades, etc.



Population Health Needs (Considerable) Improvement

- > 50% Deaths and Expenses are Preventable
- Reduction in Violence is Needed
- Transition from Acute to Chronic Care
- Lifestyle Causes of Ill-Health
 - Epidemic of Obesity and Diabetes
 - Under-Detected, Under-Treated Depression
 - Poor Child Health

Reference: HRI's White Paper, "Employer-Sponsored Wellness Programs"



Added Costs of Preventable Illness

- Depression + 70.0%
- High Stress + 46.3%
- High Blood Glucose + 34.8%
- Unhealthy Weight + 21.4%
- Tobacco Use + 19.7%
- Too-Little Exercise + 10.4%



Barriers to Effective Solutions "Resistance to Change"

- "Kick the Can Down the Road"
- Aversion to Hard Decisions
- Litigation Concerns
- Too-little Willingness to Sacrifice
- Consumer Insulation
- Lack of Individual Responsibility
- Insufficient "Will"



Solve the Challenges!

1. Solve Access
2. Re-Align Economic Incentives
3. Control Costs
4. Improve Quality
5. Improve Health of Participants



Solve the Challenges! continued

1. Solve Access

Create the "Will" for Health System Reform

Required Reading (There will be a Test!)

www.commonwealthfund.org

"A Roadmap to Health Insurance For All: Principles for Reform"



Solve the Challenges! continued

2. Re-Align Economic Incentives

Overcome Anti-Economics
 Better Define Role and Expectations
 For US' Health System
 Pay Providers for Top Performance
 Create Responsibility for Behaviors



Solve the Challenges! continued

3. Control Costs

HRI's KISS Solution to Cost Controls:

- Buy Better Change Risk Factors
- Use Better Reward Right Actions
- Use Less



Solve the Challenges! continued

■ Steps to Effective Cost Controls

1. Create (or Re-Invigorate) Your Labor/Management Committee
2. Build Awareness
3. Determine Causes of Costs
4. Identify, Jointly Consider Actions
5. Set Measurable, Accountable Goals
6. Jointly Decide on Actions
7. Plan and Implement
8. Measure, Adjust



Solve the Challenges! continued

4. Improve Quality of Care

- Jointly Define "Quality"
- Protect Against Sub-Par Care
- Buy Value (Quality) not Process
- Reward Providers for Excellence, Results
- Support Quality Improvement Initiatives
- Improve Health Literacy, Engagement

References: www.HHS.GOV/valuedriven and www.NCOA.org "The State of Health Care Quality, 2007" and www.USNEWS.com Best Health Plans Search



Solve the Challenges! continued

5. Improve Health of Participants

- Capture Senior Leaders' Support
- Collect Cause Data, ID Health Risks
- Identify, Target Possible Actions
- Jointly Decide, Implement
- Measure, Adjust
- Celebrate!



Critical Ingredients in Solving the Challenges

- Unconventional Thinking
- Awareness
- Collaboration, Cooperation, Trust
- Measurable Goals (Planning)
- Joint Leadership
- Education, Communication
- Measurement (Creates Commitment)



Results of Effective Planning and Collaboration

- Costs Under Control
- Faster/Better Movement Toward Health System Reform
- Improved Quality of Care
- Improved Health
- Added Bonuses:
 - Improved Productivity
 - Improved Participant Satisfaction



The Essential Future Changes Questions....

- "Are You:
Spectator?
Participant?
Proactive Leader?"
- "Will You Create Needed Changes,
or Just React?"



Wrap-Up

- Summary
- Q&A

Improving Health Care “Quality”. Can We? Should We? How?

Background

There is a growing recognition across the US that, to be effective, solutions to health care challenges must be focused on the specific cause(s) of the problems that need solutions. As readers will note below, health care quality is not as high as US citizens and most purchasers of health care imagine it is. Thus, there is a need for purchasers of health care to understand the current state of quality, and how (and why) to improve quality of care to an optimal state.

The Problems With Quality in the US

Purchasers of health care in the US are challenged by the continually-increasing cost of health care, and by the direct and indirect costs of less-than-optimal quality of care. Much research has suggested that as much as 30% of health care costs is the result of poor or sub-optimal quality of care (for the US, this represents a direct national cost of over \$600 billion dollars). Plan sponsors can multiply their own plan's cost by 30% to determine their plan's probable cost of insufficient quality. But there is an even larger toll for the nation and plan sponsors who purchase health care. This toll is in added indirect costs like absence-related productivity losses, disability and life insurance costs, worker training and replacement costs, and of course the toll of human and family suffering that is the result of insufficient quality (that can and should be improved). These indirect costs should be quantified and added to the direct costs of insufficient quality when considering the true “cost” of sub-optimal care.

The National Committee for Quality Assurance has written,

“While most Americans believe that the care they receive is the best that medicine and science can provide, the evidence shows a very different picture. Despite the fact that our nation spends nearly \$2 trillion a year on health care, approximately 16% of the gross national product, research shows that the quality of health care in America is, at best, imperfect, and at worst, deeply flawed”.

The Institute of Medicine (IOM), a Federal Government Agency dedicated to improving US health care quality has defined three types of quality problems:

- **Overuse:** providing a service when its potential for harm exceeds the possible benefit.

- **Underuse:** failure to provide a service when it would have produced a favorable outcome.
- **Misuse:** providing an appropriate service but when a preventable complication occurs, the patient does not receive the full potential benefit of the service.

Though not listed by the IOM, Health Research Institute believes **Errors and Misjudgments** belong on the listing above as well. For evidence, see below and the following pages for frightening statistics about the quality of health care in the US.

The Institute of Medicine's landmark 2001 report entitled, *Crossing the Quality Chasm: A New Health System for the 21st Century* documented health care quality problems in the US and summarized the magnitude of quality failures in stark terms: "Between the health care we have and care we could have lies not just a gap, but a chasm." Consider the following published evidence of less-than-optimal medical care delivered in the US:

- The Institute of Medicine (IOM) study reported a cycle of inaction on medical errors that result in an estimated 44,000 to 98,000 American deaths yearly. If medical mistakes were a disease, these almost universally undisclosed errors would be the US's fourth largest killer (immediately behind heart disease, cancer and strokes). And of course the cost of the medical care that results in these deaths is compensated by plan sponsors as completely as optimal care is paid for (a large portion of the solution to quality problems in the US can be found in this circumstance of perverse payment incentives which creates equal payments for poor and high-quality care).
- Results of a large national study published in the June, 2003 issue of *New England Journal of Medicine* found only 55% of recommended care was delivered across a wide variety of conditions and treatments. The report added that all Americans are at risk of receiving poor care, regardless of where they live, how much money they have or their race, education or health insurance.
- Nearly 90,000 people die every year, at least in part because they obtained an infection while in the hospital.
- A nationwide study of physician organizations found that physicians used less than half of the recommended care management processes for four major chronic conditions.
- The National Committee on Quality Assurance (NCQA) estimated in its 2005 report that between 37,000 and 81,000 Americans die needlessly each year because they do not receive appropriate medical care. NCQA adds that if the entire health care system performed at the level of the top accountable health plans, billions of dollars would be saved in unnecessary hospitalization expenses along with the 37,000-81,000 lives.

- Nationally, NCQA estimates low-quality health care leads to an estimated 64.7 million avoidable sick days, which is the equivalent of almost 270,000 full-time employees calling in sick for an entire year. NCQA also reports productivity losses due to low-quality care for employees who don't call in sick are equal to \$10.6 billion in lost productivity on the job.
- For more than three decades, the Center for the Evaluative Clinical Sciences at Dartmouth Medical School has documented extensive variation in Medicare use and costs among hospital regions in the country. Medicare costs and usage vary as much as twofold across many hospital regions, with little relation to differences in price or illness rates in the populations. These differences are attributable to the differences between optimal care and excessive care.
- Analyses of Medicare spending variations have found that higher spending regions of the country do not have better quality or higher rates of satisfaction than the lower spending regions.
- Physicians in the US write about 3.2 billion prescriptions per year, yet fewer than 20% of physicians use electronic prescribing (experts attest a very large portion of medication errors is simply the result of misinterpretation of handwritten prescriptions and medication instructions). The Institute of Medicine says medication errors kill 7,000 persons yearly, injure 1.5 million patients, and cost billions of dollars in care made necessary by the Rx mistakes. The IOM has called on all physicians in the US to use e-prescribing by 2010.
- According to a recent report by the National Business Coalition on Health (NBCH), health plans are making some progress in promoting quality and transparency. For example, 75% of health plans studied provide easily accessible information about prescription drug cost and appropriateness (and side effects). In contrast however, only 30% of health plans provide reasonably easily-obtained information about hospital quality differences, and worse, only 6% of health plans currently report physician performance measures related to major chronic diseases. In addition, the NBCH research confirms that less than 20% of US physicians use e-prescribing which is proven effective in preventing deadly and costly medication errors. And lastly, the NBCH report documented only 7% of plans in the study use electronic medical records that are very effective in informing all treating professionals about treatments and medications being concurrently provided by the patients' other physicians and health care professionals.
- In decades-long research and state-mandated data gathering, a state of Pennsylvania agency (the Pennsylvania Health Care Cost Containment Council, PHC4) has documented there is little relationship between the cost of care and the quality of care, and that certainly, quality cannot be judged by its price or cost. PHC4's June, 2007 *Hospital Effectiveness Report* showed some

hospitals in Pennsylvania received as much as \$100,000 for coronary bypass procedures, while others received as little as \$20,000. After adjusting for severity of patients' conditions, the high-cost and low-cost hospitals had near-identical lengths of stay and mortality rates. The PHC4 report also showed that among 20 hospitals in the Philadelphia area, two of the highest-paid hospitals had higher-than-expected mortality rates. Conclusion...judging quality by its cost is a misleading myth.

What Does it Take to Improve Quality of Care?

The first step in improving the quality of care is to recognize and accept that patients alone are largely impotent to bring about the needed changes. Deficiencies in care quality are systemic, and they must be solved by payers and providers, not patients. But payers are not clinically well versed enough to identify care insufficiencies and to create the needed clinical improvements on their own. So quality improvement initiative partnerships need to be formed between payers and providers. Bottom line...this means payers must demand and pay for higher levels of quality. And providers must make quality improvement a core value (and adopt the transparency needed to prove their quality improvement efforts are effective and continuous). Needless to say, neither of these is a small task. But both can be accomplished.

For example, leading-edge plan sponsors across the US are seeking and finding ways to improve quality of care. They realize that avoiding (or reducing the number and severity of) errors in the process of delivering medical care pays dividends in reduced human suffering as well as lower health care costs. And productivity improvements are a no-cost bonus.

The basics... leading-edge plan sponsors have learned they must define what "Quality" means, and then adopt metrics to measure changes in quality over time. The following are words frequently used to define and describe "quality" of care:

- Positive Outcomes** (Effectiveness; care based on the best medical evidence and use of best practices)
- Appropriate** (right care, right time, right site, right person with the best possible result)
- Patient Satisfactory, Patient Centered**
- Safe**
- Timely**
- Efficient**
- Equitable**
- Accessible when needed**
- Improves participants' states of health**
- Results in faster recoveries**

On the list above, all attributes of quality are important and all can be measured, but outcomes and appropriateness are the most critical. Outcomes are measured by results.

wether the patient lived or died (mortality rates), and whether the patient's condition improved or deteriorated (morbidity rates) as a result of the treatment are highly-measurable and comparable metrics of outcomes. Correctness of process (as measured by comparison to medical evidence and best practices), use of the most cost-effective site (e.g. outpatient or ambulatory care center when clinically possible instead of inpatient hospitalization), ensuring the right patient and operative site, reducing post-operative infections and complications, etc. are metrics for appropriateness.

How Can Labor and Management Improve Quality of Care?

Once labor and management in plan sponsor organizations have decided they can and should jointly pursue efforts to improve quality of care for their plan's participants, the parties can follow these steps:

1. Conduct the research and education necessary to allow both labor and management to advocate equally and vigorously for measurement of and improvements in quality of care.
2. Labor and management should discuss and jointly define (and write down) what "quality" of care means for their plan(s).
3. Once quality is defined, metrics should be agreed to for all elements of the definition of quality so a baseline measure and measurements over time can be set into motion. Providers in the medical system are very scientifically oriented. When labor and management seek improvements in quality, the providers' first questions are, "How do you define "quality", how will you measure quality, and what are your quality improvement goals?" Thorough and well thought-out answers to these questions result in good partnership initiatives to improve quality. Poor or no answers to these questions result in a continuation of today's "no progress" toward quality improvement.
4. Jointly set measurable goals for improvements in quality.
5. Identify and discuss/decide on strategies and steps to accomplish quality of care improvement goals (some examples are shown in the following section).
6. Carefully plan and implement the strategies and actions.
7. Communicate thoroughly with all stakeholders.
8. Monitor changes in baseline quality, fine-tune actions as necessary, and monitor/report changes in quality over time. Adjust as needed.

What are Some Quality Improvement Actions?

Recall from the discussion above that individual patient's actions to improve quality will be wholly insufficient. And waiting for and hoping providers will improve quality on their own without plan sponsors' strong encouragement is almost as ineffective as hoping patients will improve quality. Consequently, the key to success in quality improvement is for plan sponsors (composed of like-minded labor and management planners) to take a proactive role in improving quality by using their plan selection and purchasing decisions to buy medical care on the basis of quality and value. Ultimately, this involves rewarding providers who get it right with more patients and compensation, and at the same time, providing lesser rewards for providers with less-than-optimal results.

There are two pathways on the road to improved quality. One is to contract with already NCQA-accredited health plans or to encourage current health plans to become accredited by NCQA as soon as possible. The other path is to select or retain plans based on knowledge gained from Request for Proposals (RFP) questions like the ones below.

The first path is shorter and probably more effective than the second path, at least in the short run. The National Committee on Quality Assurance (NCQA) is a Washington, DC-based quality auditing and accreditation organization. NCQA has currently awarded various levels of accreditation to 354 health plans that serve over 50 million Americans across the US. NCQA-accredited health plans receive one of five possible levels of "Report Card" scores from NCQA that are based on extensive, in-depth reviews of data and on-site audits that are well beyond the capabilities for quality investigation by almost all plan sponsors. These Internet-listed, NCQA-accredited health plans are a strong and reliable signal that the health plan provides high quality medical care (see NCQA's web site for a listing of accredited health plans at www.ncqa.org)

The second path toward improvements in quality is for plan sponsors to use the "power of the purse" to move current plans toward the levels of results reporting and transparency required of NCQA-accredited plans. If a current health plan or those under consideration in the RFP process have chosen not to become NCQA accredited, or at least haven't accomplished that task yet, then by asking questions like the ones shown in the sample RFP questions (below), plan sponsors send a powerful signal that data and information about current levels of quality and the plan's providers' performance are needed.

Here are a few example RFP questions that relate to quality of care that are always included in HRI's RFP materials:

1. Is your health plan accredited by the National Committee on Quality Assurance (NCQA)? If yes, skip to question # __ below).
2. If your plan is not yet accredited, please describe your intent and progress toward NCQA accreditation (if applicable).
3. Describe all quality improvement initiatives your plan participates in. What are the results of your efforts to improve quality? What impact do

- your quality improvement efforts have on costs? How are these results reported to your clients?
4. How does your health plan measure and report quality improvement results to your plan sponsor clients?
 5. What is your definition of “Quality” that is being measured?
 6. Does your plan regularly identify and report about hospitals and physicians in your market areas that are more efficient and that have better quality results? How are these differences reported (i.e. costs and results per specific procedures, condition-specific treatment costs and results, episode-of-care costs and results, patients’ out-of-pocket costs)?
 7. Does your health plan use a provider payment system that rewards outcomes and appropriate medical care instead of waste and errors? If yes, what are the types of incentives offered for high-quality, high-value care (i.e. performance bonus’, elevated fee schedules, tiered networks, etc.)?
 8. How does your plan seek to improve the efficiency and effectiveness of your contracted providers (e.g. linking medical science (evidence-based and best practices) to clinical decision-making at the point of care)?
 9. Does the pharmacy portion of your plan provide transparent information about covered medications’ costs, purposes, alternatives and drug safety contra-indications that is easily accessible by patients? Do you include a drug savings calculator service for patients?
 10. Do you submit HEDIS data? If yes, please include your most recent submission of HEDIS data with your response to this RFP. If no, please provide the rates of treatment/early detection accomplished by your contracted physicians for the following:
 - A. Cervical Cancer Screening
 - B. Colorectal Cancer Screening

HRI note: A and B above are examples of 25 treatment/screening rates and various member satisfaction rates regularly provided via HEDIS (Health Employer Information Data Set) data by health plans seeking NCQA accreditation. These widely-published NCQA results (81.8% for Cervical Cancer and 52.3% for Colorectal Cancer screening for example) are very credible and worthwhile benchmarks for comparison in plans that are not yet NCQA accredited. It is very important for plan sponsors to know how their current plan(s) or plans under consideration are performing in the 25 very important quality of care measures. But perhaps even more important, even in accredited plans, the screening for these dangerous cancers is not being performed in 28.2% of cases for Cervical Cancer and in 47.7% of Colorectal Cancer screening opportunities. So there is still room for improvement in quality even in accredited plans. However, ample evidence shows that plans generally not required to report transparent data about rates of treatment and screening via HEDIS data are somewhat low-performing compared to reporting plans. Requiring answers to

questions like the above helps move non-accredited plans toward transparent reporting and thus improvements in quality of care.

There are other very worthwhile steps labor and management can take to improve quality of care. Although the discussion above confirms plan participants are not effective in improving the medical system's quality, participants can be taught how and encouraged to access better quality for their own personal circumstances. But teaching participants how to access higher-quality care in their own circumstances requires a pre-step: education that changes participants' usual perceptions that US health care is the best in the world and that they should trust their providers without question or scrutiny to provide patients with the best care possible. Unfortunately, health care in the US is not world class when the usual global measures of health of nations' populations are considered. Compared to all developed nations, according to the World Health Organization, the US ranks 37th, our life expectancy ranks 45th, and the US' infant mortality rate is worse than almost all developed nations.

Once plan participants are made aware of the above and the dismal statistics about medical mistakes included early in this White Paper, the next step is to equip participants with currently-available tools to allow them to choose physicians and hospitals with the best published quality outcomes. Here are some of the tools available (these tools are seldom used because they're largely unknown):

- Medicare's Hospital Comparisons website (www.hospitalcompare.hhs.gov). This website shows how a given hospital compares with national averages for death rates from common illnesses as well as the hospital's performance on 21 quality measures. www.medicare.gov/NHCcompare/home.asp provides the same type of information about nursing homes.
- The American Hospital Association (through the Hospital Quality Alliance (HQA)) provides data on hospital quality in selected clinical topics. www.aha.org/aha_issues/HQA/index.jsp
- HealthPages.org publishes consumer reviews of doctors and hospitals and provides information about different medical conditions (www.healthpages.org)
- *U.S. News & World Report* publishes annual rankings of America's best health plans and best hospitals. (www.usnews.com)
- The National Committee for Quality Assurance (NCQA) provides Report Card-type information on health plans and physician groups (www.healthchoices.org)
- The Minnesota Community Measurement Program provides comparative data on provider group performance on key clinical measures and overall statewide results. www.mnhealthcare.org

- Pennsylvania Health Care Cost Containment Council (PHC4)
PHC4 regularly publishes outcomes and costs on a Pennsylvania provider- and procedure-specific basis. www.phc4.org
- State Snapshots: The Agency for Healthcare Research and Quality (AHRQ) (www.ahrq.gov) provides a Web-based tool to help people understand the strengths, weaknesses and opportunities for improving health care quality in their states. The Snapshots rank each state in the US on 15 important measures of health care quality and show each state's performance relative to regions and the US. The report includes an in-depth information on diabetes treatment. (www.qualitytools.ahrq.gov/qualityreport/2005/state/summary/intro.aspx)
- The American Heart Association, American Stroke Association and NCQA offer a program to recognize the quality of care provided by doctors for people with cardiovascular disease or who have had a stroke. www.ncqa.org/harp A similar program provides data on diabetes care. www.ncqa.org/hsrp

As an additional step, labor and management in plan sponsor organizations should download, print and thoroughly review the *Value-Driven Health Care Purchasers Guide* issued by the National Business Coalition on Health Care (NBCH). This 72-page *Purchasers Guide* is filled with tips and actual case studies on how plan sponsors and coalitions are improving the quality of health care in the US.

Summary

Labor and management in plan sponsor organizations can improve health care quality if they decide to do so. The first step is becoming familiar enough with quality problems and the impact of sub-optimal quality on their plans and participants so they gain the “will” to embark on quality improvement efforts. An additional very important step is jointly agreeing to the plan sponsor's definition of “Quality”, and choosing the metrics to measure results and changes over time. Plan participants can be allies since their collective actions in choosing higher-quality providers will help elevate the quality of all providers, not just the providers who currently have superior results (this process will receive a boost if plan sponsors reward high-quality care better than sub-optimal care).

Additional Resources for Further Research

The Agency for Healthcare Research and Quality (AHRQ) is charged with improving the quality, safety, efficiency and effectiveness of health care in the US. www.ahrq.gov

The Office of the National Coordinator for Health Information Technology (ONC) provides leadership for the development and implementation of an interoperable health

information technology system to improve health care quality and efficiency.
www.hhs.gov/healthit

American Health Quality Association (AHQA) works with Medicare and quality-improvement professionals to improve the quality of health care in the US www.ahqa.org

The Foundation for Healthcare Quality supports programs in performance measurement, patient safety, information technology and health data surveillance and analysis.
www.qualityhealth.org

The Institute for Healthcare Improvement (IHI) is dedicated to improving health care in the world. IHI organized the 100,000 Lives Campaign. www.ihl.org/ihl

The Institute of Medicine (IOM) provides evidence-based analyses and guidance on health and science. www.iom.edu

The Leapfrog Group experiments with ways to link purchasers' payments with improvements in patient safety. www.leapfroggroup.org

The National Business Coalition on Health is dedicated to value-based purchasing of health care services. www.nbch.org

The National Business Group on Health (NBGH) represents 245 large US employers in seeking innovative solutions to health care challenges. www.whbh.org

The National Committee for Quality Assurance (NCQA) is the leading health plans accrediting organization in the US. NCQA also maintains the Health Plan Employer Data and Information set (HEDIS). www.ncqa.org

The Physician Consortium for Performance Improvement (Consortium) was founded by the American Medical Association. Its intent is to enhance quality of care and patient safety by developing, testing and maintaining evidence-based clinical performance measures and measurement resources. www.ama-anmn.org/ama/pub/category/2946.html

The Pharmacy Quality Alliance (PQA) seeks to improve health care quality and safety by measuring performance at the pharmacy and pharmacist levels. www.pqaalliance.org

The Ambulatory Care Quality Alliance (AQA) seeks to improve health care quality by measuring, reporting and improving performance at the physician level.
www.aqaalliance.org

Talking Quality is a web site designed for people and organizations trying to educate consumers about health care quality and for those who provide consumers with information on the performance of health plans and providers. www.talkingquality.gov

Health Research Institute's White Papers Series

Employer-Sponsored Wellness Programs

Background

Employers in the US pay for about half of the US' \$1.9 trillion dollar health care cost (that's 16% of the Gross Domestic Product). Over half of these expenditures (and over half of all deaths in the US) are caused by preventable illnesses and accidents. According to the Partnership for Prevention, over 95% of the nation's expenditures for medical care are for diagnosing and treating disease only after it becomes manifest. This means less than 5% is being invested in preventing the illnesses and accidents that cause over half of US expenditures and US deaths annually.

What is "Wellness"?

"Wellness" should be defined by each group seeking to improve the health and wellness of its population, but generally, "Wellness" is defined as: *"The condition of being healthy or sound, especially as a result of proper diet, exercise, etc., and in maximum physical or mental health.* Some plan sponsors decide to seek optimal health instead of maximum, and some also address the physical, social, spiritual and emotional well-being of individuals.

What are Wellness Programs?

Wellness programs are designed to *prevent illness and accidents, reduce their severity when they occur, and to detect illness in its earliest stage* (and ultimately, *to improve participants' quality of life*). Employers pay for most of the cost of health care for their workers so there is a growing recognition that it is in the employer's best interest (as well as the patient's interest) to adopt wellness programs. After all, the stroke or heart attack that doesn't occur doesn't have to be paid for. In fact, according to recent research, about 62% of US employers currently offer some form of wellness program (over 90% of large employers offer at least some form of health promotion or wellness programs). And workers gain by wellness programs because employees also have to pay their share of costs for preventable illness in terms of out-of-pocket costs, and the toll of human and family suffering is added as well.

What are the Usual Components of a Wellness Program?

The following are some of the most prevalent programs offered as part of wellness programs:

<u>Prevention</u>	<u>Screening</u>	<u>Education</u>	<u>Health Promotion</u>
--------------------------	-------------------------	-------------------------	--------------------------------

Smoking Cessation	Cholesterol	Illness Detection	Empowerment
Safety	Diabetes	Resources Wise-Use	Stress Control
Weight Loss	Blood Pressure	Medicine Awareness	Health-Risk
Fitness	Cancer	Disease Management	Awareness
Immunizations	Nutrition Screening	Well-Awareness	Engagement

What are Worksite Health Promotion (Wellness) Programs?

Wellness at the worksite refers to a systematic and well-planned program designed to enhance the health of the company/employer and its most valuable asset, its employees (there are 110 million workers in the US and most of them spend the majority or all of their workday at the employer's worksite). In order to reach the greatest health improvement potential, programs may include initiatives based in the worksite as well as in the employees' communities, clinics and homes. These efforts may take the shape of awareness education, behavior and lifestyle change and the creation of supportive environments. The ultimate goal of worksite health promotion is to create a culture which values and meets both individual and organizational needs for health improvement.

What are Some of the Goals for Workplace Wellness Programs?

- Improving Workers' Health and Keeping Employees Healthy
- Reduce the Cost, Incidence and Severity of Preventable Illness
- Reduce the Future Risk of Preventable illness and Accidents
- Attract and Retain Employees
- Protect the Employer's Investment in Employee Training and Development
- Improve Morale
- Increase Life Expectancy
- Reduce Workers Compensation Costs
- Improve Job Satisfaction
- Increase Vitality, Attitudes and Empowerment
- Reduce Absenteeism and Disability
- Improve Productivity
- Elevate Employers' and Employees' Visibility and Social Responsibility
- Reduce the Cost, Incidence and Severity of Preventable Accidents
- Link Employees, Dependents and Retirees with Community and Other Health Promotion/Wellness Resources
- Evaluate Outcomes and Identify New Opportunities for Health Improvement

Why Target Employees Who Have (or are Headed Toward) Preventable Illnesses?

In addition to the potential for significant improvements in quality of life and life expectancy for participants in wellness programs, there is a significant and negative impact on companies' bottom lines resulting from medical plan participants' ill health. According to *Occupational Health Management*, the following are the additional costs of these (preventable) health conditions:

Depression	+ 70.0%
High Stress	+ 46.3%
High Blood Glucose	+ 34.8% (Diabetes)
Unhealthy Weight	+ 21.4%
Tobacco Use	+ 19.7%
High Blood Pressure	+ 11.7%
Little Exercise	+ 10.4%

What are the Costs of Wellness Programs?

The investments made by employers in wellness vary significantly since almost all programs are tailored to the employer's specific situation, needs, resources, commitment, etc. However, in general, most reports and estimates of cost range from \$100-150 PEPY. This equates to about 1-2% of medical care costs, but it is important to note that employers are already paying for the lack of wellness programs in the form of lost opportunity for savings costs.

Is There a Positive Return on Investment (ROI) From Wellness Programs?

Research of published studies shows a well-documented positive return on investment (ROI) of \$2 to \$16 for each dollar invested in wellness programs.

Here are some specific examples:

Band of America	\$6.00/\$1
Coors Brewing	\$6.15/\$1
Travelers Insurance	\$3.40/\$1
Blue Cross (IN)	\$2.51/\$1
DuPont Company	\$2.05/\$1
Johnson & Johnson	Cost Savings of \$225/Employee
Motorola	Wellness Program Participants = 2.5% Annual Cost Increases (Compared to 18% for Same Participants in Previous Years)

Other employers with positive (but not publicly published) results are:

General Electric	City of Birmingham, AL
Chrysler Corporation	Sunbeam/Oster Company
Steelcase	Textron
Duke University	Nike Corporation
Union Pacific Railroad	Lands End Corporation
Blue Cross of California	Boeing Company

What are Some Metrics to Measure the Effectiveness of Wellness Programs?

1. Absenteeism
2. Health Risks Ratings
3. Health Care Costs and Utilization Changes Over Time
4. Cost Effectiveness (Cost/Benefits ROI Ratings)

5. Others as Designed by Wellness Committees (e.g. Participant Satisfaction, etc.)

Minimum Steps to Plan Effective Wellness Programs

1. Capture Senior Leadership's Support (Employer's, Union's and Employees/Dependents/Retirees)
2. Create Cohesive Wellness Teams
3. Collect Data to Drive and Measure Health Improvement Efforts
4. Create an Operations Plan and Implementation Timetable
5. Choose Appropriate Programs Based on Demonstrated Needs
6. Decide on Roles and Responsibilities
7. Create a Supportive Environment
8. Implement
9. Consistently Evaluate and Report Outcomes
10. Monitor and Adjust as Needed
11. Communicate Well and Often Throughout Process
12. Celebrate Success!

Additional Wellness and Health Promotion Resources

WELCOA (Wellness Councils of America)
Office of Disease Prevention and Health Promotion
Healthy People 2010
Steps to a Healthier US Initiative
National Institute of Diabetes, Digestive & Kidney Diseases
President's Council on Physical Fitness & Sports
Substance Abuse & Mental Health Services Administration
National Wellness Institute, Inc.
Partnership for Prevention
National Coalition for Promoting Physical Activity
America on the Move
American Association of Health Plans
Department of Health and Human Services Data Council
Healthfinder™
Health Insurance Association of America
National Center for Health Statistics
National Committee on Vital and Health Statistics

For Additional Information, Contact William E. Hembree, Director, Health Research Institute. (925) 676-2320 or hembree_hri@att.biz